PRINTED: 12/04/2009 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE SU COMPLE		
		085026	B. WI	10 _		10/2	7/2009	
NAME OF F	ROVIDER OR SUPPLIER		•	4	REET ADDRESS, CITY, STATE, ZIP CODE 1031 KENNETT PIKE BREENVILLE, DE 19807			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 000 F 157 SS=D	deleted. F279 remayere made to F280 changes made to F280 changes made to see the made to F280 changes made to see the made to F280 changes made to see the made the F280 contained in this resolution of the consequence of the sample included for residents and twelver residents in Stage eighteen (18) residents in must immore consult with the resident involving injury and has the intervention; a sign physical, mental, of deterioration in her status in either life clinical complication significantly (i.e., a existing form of treconsequences, or treatment); or a detine resident from the §483.12(a).	owing IDR request. F225 was ains unchanged. Text changes of and F314. There were no acope and severity of any tags. QIS annual survey was acility from October 19, 2009 7, 2009. The deficiencies aport are based on views, review of residents of review of other indicated. The facility census survey was 41. The survey orty (40) census sample (40) admission sample 1. The Stage 2 sample totaled	-157 1. 2.	Not doctor according to Lice regulation of the contract on the	e physician was notified of the rentinence status at the time of the tification of the appropriate particumented in the medical record cidents, injuries, and for significal condition or treatment. Ensed staff will be in- serviced or sulatory requirement related to diffication. documented notification will be the 24-hour report which is reviet the DON/ADON.	e survey. by will be for nt changes the indicated	12 30 OF	
	Kum a	m Carr Calm	<u>-</u>	<u>زم</u>	trator	<u> </u>	19	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

11:11 Stonegates

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;		(X2) MULT A, BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		085026	B. WING _		10/2	7/2009
NAME OF P	ROVIDER OR SUPPLIER		. 4	REET ADDRESS, CITY, STATE, ZIP CO 1031 KENNETT PIKE SREENVILLE, DE 19807	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	n should be	(X5) COMPLETION DATE:
F 157	and, if known, the ror interested family change in room or specified in §483.1 resident rights underegulations as specified the section. The facility must rethe address and phlegal representative. This REQUIREMED by: Based on record redetermined that the physician when one sampled Stage 2 rechange in physical. R45 was readmitte hospitalization, on included anemia, diminimum Data Set 7/1/09 indicated the and bladder. A qual 8/29/09 indicated fincontinent-2 or more review of the clinic R45's physician had decline in bladder. During an interview at 3:10 PM, she collegion intively state who specifically state with a second continent of the clinic representation of the clinic	so promptly notify the resident esident's legal representative member when there is a roommate assignment as 15(e)(2); or a change in er Federal or State law or bified in paragraph (b)(1) of cord and periodically update one number of the resident's or interested family member. NT is not met as evidenced eview and interview it was efacility falled to notify the equipment of the facility falled to notify the equipment of the facility, post of 18 esidents had a significant status. Findings include: If to the facility, post of 18 esident and depression. The (MDS) assessment, dated at R45 was continent of bowel of R45 was "occasionally one times a week but not daily." eal record lacked evidence that did been notified regarding the	F 157			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		IPLE CONSTRUCTION	(X3) DATE S COMPLI	X3) DATE SURVEY COMPLETED	
		085026	B. WIN	łG_		10/2	27/2009	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 157 F 241 SS=D	(R45's physician) of asked if he had been decline in bladder of was unable to say the informed. The facility failed to decline in bladder of 483.15(a) DIGNITY The facility must promanner and in an elenhances each resided in the decline in the facility must promanner and in an elenhances each resided in the decline in the facility must promanner and in an elenhances each resided in the decline in the facility must promanner and in an elenhances each resided in the decline in the facility must promanner and in the decline in the facility must promanner and in the decline in the facility must promanner and in the decline in the d	n 10/27/09 at 10:30 AM, when in informed of the resident's continence, he stated that he hat he recalls having been notify R45's physician of her continence.		241				
	by: Based on observatifacility failed to ensign (R9, R11 and R23) manner while being Findings include: Observation of the dining room on 10/2 three (3) CNAs (E9 three (3) residents as same table. Through minimal interaction residents. E9, E10 interacting more free than with the residents are table. R11 was seated side geri-chair with E9 seated the side of the same table.	on it was determined that the ure that three (3) residents were treated in a dignified fed their evening meal. evening meal in the main (21/09 at 6:00 PM revealed E10 and E11) were feeding R9, R11 and R23) at the hout the meal there was between the aides and the and E11 were observed quently amongst themselves nts they were feeding. leways next to the table in a seated behind the table on the R11 was heard saying, "may more?" at least three times was noted looking forward	expe and : servi resid digni desig	ealteries stat ice. ient ity a	th care staff will be in-serviced rence. General rules regarding interfer will be posted in both pantry and Mursing supervisor will monitor to to ensure the dining experience and quality of life of our residents ted to oversee the dining room dring will be on going for all meals.	eraction be- reas in addi- the dining of e is one the s. A nurse w luring the n	tween resider ition to the in- experience of at promotes will be	nt - 'ou

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		085026	B. WING _		10/27/2009
NAME OF P	ROVIDER OR SUPPLIER		4	REET ADDRESS, CITY, STATE, ZIP CODE 031 KENNETT PIKE BREENVILLE, DE 19807	"""
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F 241 F 274	being inattentive to 483.20(b)(2)(ii) RE	the resident's needs. SIDENT ASSESSMENT-	F 241 F 274	F-274	
\$\$=D	A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced			 The facility acknowledges the assessment performed on 8 incorrect. The resident is or appropriate schedule with a assessments being complete. An audit of MDS schedule we reviewed to determine if the appropriate assessment is be completed for all new admissions. The assessment coordinator the MDS schedule monthly if and assurance that the prop 	/29/09 was n the appropriate ed. vill be e leing ssion and re- r will review for accuracy per
	interview, it was de to initiate a significa one (1) resident (R Stage 2 sample. F	_		assessment is being complet 4. The DON/designee will revie admissions and re-admission the appropriate MDS.	ew all new
	hospitalization, on (d to the facility, post 3/24/09 with diagnoses that ementia and depression.			11)30 69
	admission Minimun assessment, dated cognitive skills for d "modified independ situations only." Th	ial record revealed an n Data Set (MDS) 7/1/09 which indicated R45's daily decision making were lence-some difficulty in new is same MDS indicated the mited physical assistance of			ana angoing

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES					ONB NO. 0938-0391		
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, i		085026	B. WI	NG_	and the first of t	10/2	7/2009
NAME OF P	ROVIDER OR SUPPLIER			1	TREET ADDRESS, CITY, STATE, ZIP CODE 4031 KENNETT PIKE GREENVILLE, DE 19807		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	FIX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPLICATION OF CORRECTIVE ACTION SHOWS A CORRECTIVE ACTION SHOWS A CORRECTIVE ACTION OF CORRECTIVE	DULD BE	(X5) COMPLETION DATE
F 274 F 279 SS=E	one person for tran and was continent of the quarterly MDS indicated R45's cogmaking were "mode poor; cues/supervis required extensive use and hygiene, a incontinent-bladder not daily" During an interview 2 PM, E8 (MDS Coa significant change The facility failed to change assessment completed the 8/29 483.20(d), 483.20(d), 483.20(d). A facility must use to develop, review a comprehensive pla. The facility must deplan for each reside	sfer, toilet use and hygiene of bowel and bladder. assessment, dated 8/29/09 gnitive skills for daily decision erately impaired-decisions sion required" and the resident assistance for transfer, toilet nd was "occasionally", 2 or more times a week but on 10/26/09 at approximately ordinator) acknowledged that a sasessment was indicated. Identify that a significant at was indicated and instead 1/09 quarterly MDS. (x)(1) COMPREHENSIVE the results of the assessment frand revise the resident's nof care. Evelop a comprehensive care ent that includes measurable	79 1. (2, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1, 1,	Nur revi	e plans for all four residents have rsing will be educated on the care ise care plans as indicated.	plan proces	ss to review a
:	objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive		 Nurses will review resident care plans when competing m summaries to determine if any changes or revisions are 				

- assessment.
- The care plan must describe the services that art to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under
- nd
- required.
- 4. The 24-hour report which is completed by the nursing supervisor on each shift and is reviewed daily by the DON/ADON will indicate if the care plan was evaluated or revised.
- The DON/ADON will review the care plan for accuracy.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LTIPLE CONSTRUCTION DING	(X3) DATE SI COMPLE	(X3) DATE SURVEY COMPLETED		
		085026	B. WING		10/2	7/2009		
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F 279	§483.10, including under §483.10(b)(4	the right to refuse treatment	F 27	79				
	was determined the care plan for four (4	ecord review and interview, it at the facility falled to develop a l) residents (R10, R41, R37 sampled Stage 2 residents.						
	to 7/09, R45 was or The clinical record developed periods continued to the cuimplemented approache incontinence, the plan of care for this ln an interview with 10/26/09, she acknincontinence was not a reconstruction of the incontinence was not a reconstruction of the incontinence was not a reconstruction of the incontinence was not a reconstruction and incontinence was not a reconstruction of the incontinence was not a rec	nical record revealed that prior ontinent of bowel and bladder. Indicated that during 7/09, R45 of incontinence which reent time. Although the facility priate interventions to address ley failed to develop a written problem. E8 (MDS Coordinator) on owledged that a care plan for ever developed for R45. In the facility on 6/30/09. On as written for R10 to receive a due to variable meal intakes, ian's notes stated that a believed due to R10's weight Implemented interventions to the interventions to the problem was first E8 (MDS Coordinator) on		 Care plans for all four updated Nursing will be educa process to review and indicated. Nurses will review res competing monthly suif any changes or revised. The 24-hour report winursing supervisor on reviewed daily by the indicate if the care pla revised. The DON/ADON will reaccuracy. 	ted on the care plansident care plansident care plansimmeries to desions are required in the complete each shift and in the complete planside in the complete each shift and in the complete each shift and in the complete planside in the complete each shift and in the care planside each shift and in the care eac	plan ins as s when termine ed, ed by the s d or		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE \$1 COMPLE	
		085026	B. WING	, , , , , , , , , , , , , , , , , , , ,	10/2	7/2009
NAME OF F	ROVIDER OR SUPPLIER	•	40	EET ADDRESS, CITY, STATE, ZIP COI 131 KENNETT PIKE REENVILLE, DE 19807		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 279	10/26/09, she acknown for weight loss was manner. 3. Review of R41's on 10/9/09 a physic "Hospice consult. A On 10/15/09 a "Hospice consult. A On 10/15/09 a "Hospice consult. A On 10/15/09 a "Hospice services. Review of the facility care plan that incluand hospice service plan was not complete and hospice service plan was not complete only included the provided by the hospice residual to the facility care plan was a hospice residual which ones the A. Review of R37's physician's order, devery 4 hours as no On 9/28/09 the ording every 4 hours as Review of the medi (MAR) revealed that 8 doses of the Atin 10/26/09. Despite the facility failed to dev R37's agitation/beh	owledged that R10's care plan not completed in a timely clinical record revealed that sian's order was written for dmit to hospice if appropriate." spice ention/Plan" was completed 41 was admitted to hospice by care plan for R41 lacked a ded a coordination of facility as. The separate hospice care sete and did not list goals and are to be provided by hospice, a amount of hours being spice service. In failed to include that R41 dent and failed to identify the hat the facility would provide hospice would provided. Clinical record revealed a sted 6/25/09 for Ativan 0.5 mg seded for anxiety/restlessness. For was increased to Ativan 1 is needed for agitation/anxiety. Cation administration record to R37 received approximately and between 9/14/09 and the increased use of Ativan, the elop a plan of care to address	F 279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		085026	B. WING		10/27/2009		
NAME OF P	ROVIDER OR SUPPLIER		40	IET ADDRESS, CITY, STATE, ZIP CODE 31 KENNETT PIKE REENVILLE, DE 19807			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLETION		
F 279	addressing R37's a	age 7 acknowledged that a care plan agitation/behaviors was lacking. 10(k)(2) COMPREHENSIVE	F 279 F 280				
SS=D	CARE PLANS The resident has the incompetent or other parts.	ne right, unless adjudged erwise found to be	F-280				
	participate in plann changes in care ar A comprehensive of within 7 days after	care plan must be developed the completion of the	1.	Resident 53 has an appropr which he finds to be satisfact 51's care plan was updated the appropriate PT recommo 8/21/09.	tory. Resident on 8/25/09 with		
comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed		2.	All care plans will be reviewed based on new interventions documented as such when in Nursing staff will be in-servicular process.	and will be indicated.			
		eam of qualified persons after	3. All incidents, new order clinical conditions will be the 24-hour report and applan as appropriate. 4. The shift supervisor will report and cross referenced care plans to ensure that 2 f 18 sampled stage valuated and 5. The ADON/DON will more clinical conditions will be the 24-hour report and plan as appropriate. 4. The shift supervisor will report and cross reference to the 25 been reviewed and revi		• •		
	by: Based on record redetermined that the residents' (R51 and 2 residents, care parevised as needed				nurses notes and re plans have or the care		
	impaired skin integ	4 care plan entitled "actual pity: Ankle (Stage 3) and dated 10/20/09 revealed the			and congoing		

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		085026	B. WIN	IG _	÷.	10/2	7/2009
NAME OF F	ROVIDER OR SUPPLIER			4(EET ADDRESS, CITY, STATE, ZIP CODE 031 KENNETT PIKE REENVILLE, DE 19807		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 280	cushion chair cushi interchangeable air and evenly distribut and reposition q 2-4 redness". In an interview with stated that R53 was cushion and was ph several different cushowever, the reside remove them. E7 st cushion R53 was st. According to R53's Sheet" dated 10/20/pressure sore, the cintervention was the On 10/22/09 E4 (LF "Tuesday" 10/20/09 chair cushion. According to the Wood dated 10/22/09 of R current preventative 10/20, gel cushion in 10/22/09". R53's care plan on dated 10/20/09 was reflect the interventicushions in wheel co	ons: "Provide ROHO on that has individual cells that allow air to slowly e body weight pressure), Turn thrs. and assess skin for E7 (CNA) on 10/22/09, she refusing to use the chair nysically removing it. E7 stated shions were implemented, int would always ask staff to rated she was unsure which uppose to be using currently. "Wound Evaluation Flow '09 for the Stage 2 sacral current preventative	F2	280	DEFINITION 1)		
	2. R51 was admitted	d to the facility on 8/3/09 with ded dementia, osteoporosis					•

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (DENT)FICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION		X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER ATES		40	EET ADDRESS, CITY, STATE, ZIP CO 31 KENNETT PIKE REENVILLE, DE 19807	ODE		
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F 280	reports revealed that the following falls was 8/8/09 - resident bathroom with a CN bathroom, tipped for area, lowered to the On 8/11/09, the attended in the identified R51' and recommended. A PT screen and explication on 10/29/0 recommended to "(roller walker) 2 per cueing". The facility R51's care plan who address PT's recommended to "safety awareness, twhen ambulating when ambulating when ambulating when ambulating when and injuries. b. An incident report observed by E12 from "getting up, grabbed knee and elbow. Coprevent fall. Reside on reclining chair", want to go to bed the together the care per safety alarm, walker a Time of incident was incident, the care per R51's requested between the care per R51's requested between the care per safety alarm, walker a time of incident was incident, the care per R51's requested between the care per R51's r	nical record and incident at this resident experienced ith resulting injuries: was ambulating to the IA, ran Into a wheelchair in the IA, ran by CNA. ending physician's progress ambulatory dysfunction/falls	F 280				
			ii			L	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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F 280	10/16/09 at 2117 (sin the living room, farea on head" and sized cut on forehe kneeright knee hibed". The facility falled to occurred at the sar	ther incident report dated 2:17 PM) stated that R51, while ell "onto kneeshit frontal sustained "very small open pin adskin tear on right urt". R51 stated "I want to go to evaluate R51's falls that ne time of the night and failed lan accordingly to reflect R51's	F 280			
F 314 SS=D	rolling walker dated individualize the int physical therapy recontact guard on 8/guard on 8/guard on 8/21/09. A reviewed the falls s failed to include net approaches such a the care plan revisit 483.25(c) PRESSUBased on the compresident, the facility who enters the facility who enters the facility and individual's clinical	s reduction in medications in ons. PRE SORES Prehensive assessment of a must ensure that a resident lity without pressure sores ressure sores unless the condition demonstrates that	F 314		•	•
	pressure sores reci services to promote prevent new sores	ble; and a resident having alves necessary treatment and healing, prevent infection and from developing.				

F 314 Continued From page 11 Based on observation, record review and interviews, it was determined that the facility failed to ensure one (1) resident (R53) out of 18 sampled stage 2 residents, received the necessary treatment and services to prevent new sores from developing. R53 was admitted to the facility with a Stage 3 right ankle pressure sore. Twenty two days after admission to the facility, R53 developed a Stage 2 pressure ulcer on the sacrum. Findings include: R53 was admitted to the facility on 10/8/09 from the Hospital with diagnoses that included S/P Fracture (FX) Right (R) Rib, Fractured Right Clavicie, Stage 3 right outer ankle pressure ulcer and peripheral neuropathy. According to R53's facility "Admission Assessment" dated 10/8/09, his buttocks were "reddened with no open areas", R53's Medicare 5-day Minimum Data Set (MDS) assessment atted 10/18/09 stated that this resident's cognitive skills for daily decision-making were "modified independence - some difficulty in new situations only". R53 needed extensive physical assistance of one person for bed mobility and all other activities of daily living (ADLs). R53's Braden Scale assessment for Predicting Pressure Sore dated 10/9/09 indicated that this resident was assessed to have a potential problem/risk factor for friction and sheer (scored).	OFIAIFI	10 LOW MEDIOVIVE	O MILDIONID SERVICES				CIVID NO.	0820-0381
NAME OF PROVIDER OR SUPPLIER STONEGATES Continued From page 11 Sased on observation, record review and interviews, it was determined that the facility failed to ensure one of 1, resident (RS3) out of 18 sampled stage 2 residents, received the nacessary treatment and services to prevent new sores from developing. RS3 was admitted to the facility, with a Stage 3 right ankle pressure sore. Twenty two days after admission to the facility, RS3 developed a Stage 2 pressure ulcer on the sacrum. Findings include: R53 was admitted to the facility on 10/8/09 from the Hospital with diagnoses that included S/P Fracture (RX) Right (R) Rt), Fractured Right Clavicie, Stage 3 right outer ankle pressure ulcer and peripheral neuropathy. According to R63's facility "Admission Assessment" dated 10/8/09, his buttocks were "reddened with no open areas", R53's Maclicare 5-day Minimum Data Set (MDS) assessment dated 10/16/03 stated that this resident's cognitive skills for daily decision-making were "modified independence - some difficulty in new situations only", R53 needed extensive physical assistance of one person for bed mobility and all other activities of daily living (ADLs). R53's Braden Scale assessment for Predicting Pressure Sore dated 10/9/09 indicated that this resident was assessed to have a potential problem/risk factor for friction and sheer (scooped 2), due to " skin probably slides some extent against sheets, occasionally sildes down in chair or bed", and "spends majority of each shift in bed or chair".	STATEMENT AND PLĄN C	OF DEFICIENCIES OF CORRECTION		1			(X3) DATE SU COMPLE	JRVEY TED
NAME OF PROVIDER OR SUPPLIER STONEGATES SUMMARY STATEMENT OF DEPICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LEC IDENTIFYING INFORMATION) F314 Continued From page 11 Based on observation, record review and interviews, it was determined that the facility failed to ensure one (1) resident (R52) out of 18 sampled stage 2 residents, received the necessary treatment and services to prevent new sores from developing. R53 was admitted to the facility, R53 developed a Stage 2 pressure ulcer on the sacrum. Findings include: R53 was admitted to the facility on 10/8/09 from the Hospital with diagnoses that included S/P Fracture (FX) Right (R) Rib, Fractured Right Clavicle, Stage 3 right outer ankle pressure ulcer and peripheral neuropathy. According to R63's facility "Admission Assessment" dated 10/8/09, his buttocks were "reddened with no open areas". R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/8/09, his buttocks were "reddened with no open areas". R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/8/09, his buttocks were "reddened with no open areas". R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/8/09, his buttocks were "reddened with no open areas". R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/8/09, his buttocks were reddened with no open areas". R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/8/09, his buttocks were reddened with no open areas". R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/8/09, his buttocks were reddened with no open areas". R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/8/09, his buttocks were reddened with no open areas". R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/8/09, his buttocks were reddened with no open areas". R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/8/09, his buttocks were for dated that this resident was assessed to have a potential problem/lisk factor for friction and sheer (scoored 2), due to, "			085026	B. Wi	NG		10/2	7/2009
PROVIDED SHAPEY OF A PERCENCISS (EACH DEPICIES OF WHAT EACH DEPICE				•	44	031 KENNETT PIKE		
Based on observation, record review and interviews, it was determined that the facility failed to ensure one (1) resident (R53) out of 18 sampled stage 2 residents, received the necessary treatment and services to prevent new sores from developing. R53 was admitted to the facility with a Stage 3 right ankle pressure sore. Twenty two days after admission to the facility, R63 developed a Stage 2 pressure ulcer on the sacrum. Findings include: R53 was admitted to the facility on 10/8/09 from the Hospital with diagnoses that included S/P Fracture (FX), Right (R) Righ. Fractured Right. Clavicle, Stage 3 right outer ankle pressure ulcer and peripheral neuropathy. According to R53's facility "Admission Assessment" dated 10/8/09, his buttocks were "reddened with no open areas". R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/16/09 stated that this resident's cognitive skills for daily decisionmaking were "modified independence - some difficulty in new situations only". R53 needed extensive physical assistance of one person for bed mobility and all other activities of daily living (ADLs). R53's Braden Scale assessment for Predicting Pressure Sore dated 10/9/09 indicated that this resident was assessed to have a potential problem/risk factor for friction and sheer (scored 2.), due to, " skin probably sildes some extent against sheets, occasionally sildes some extent against sheets, occasionally sildes some in chair or bed", and "spends majority of each shift in bed or chair".		(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF	ıx	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE
10/09/09 on "Actual alteration in Skin Integrity" but did not document or identify the areas of actual	F 314	Based on observation interviews, it was do to ensure one (1) in sampled stage 2 respectively making with a Stage Twenty two days at R53 developed a Stacrum. Findings in R53 was admitted the Hospital with diffracture (FX) Right Clavicle, Stage 3 right and peripheral neurolatility "Admission whis buttocks were "R53's Medicare 5-cassessment dated resident's cognitive making were "modifficulty in new situextensive physical bed mobility and all (ADLs). R53's Braden Scale Pressure Sore date resident was asses problem/risk factor 2), due to, " skin against sheets, occor bed", and "spen or chair". The facility initiated 10/09/09 on "Actual interviews and interv	lon, record review and etermined that the facility failed resident (R53) out of 18 sidents, received the facility, received the facility failed residents, received the facility for the facility of the facility, stage 2 pressure ulcer on the include: It to the facility on 10/8/09 from agnoses that included S/P of the facility on 10/8/09 from agnoses that included S/P of the facility on 10/8/09 from agnoses that included S/P of the facility on 10/8/09 from agnoses that included S/P of the facility on 10/8/09 from agnoses that included S/P of the facility on 10/8/09 from agnoses that included S/P of the facility on 10/8/09 from agnoses that included S/P of the facility of each shift in bed in a care plan for R53 dated a care plan for R53 dated a lateration in Skin Integrity" but in the facility of the fac		1. 2.	All residents have appropriate to services to prevent pressure uld assessments are conducted with Findings are documented and in implemented as appropriate. Pressure ulcer care plans will be reflect actual alteration in skin documentation will include the stage of the wound on the care. The ADON/designee will review and wound care documentation ensure the care plan has been revised for appropriate interved documentation of alteration in	treatment a cers. Week th nurse/C. ntervention e updated to integrity for s. The location and plan. withe care provided a nterviewed a ntions and skin integri	and ly skin N.A. ns to or all nd hity is

	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE S COMPLE	
		085026	B. WING		10/2	7/2009
NAME OF F	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP 4031 KENNETT PIKE GREENVILLE, DE 19807	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 314	"Provide pressure r "provide cushion to 2- 4 hours" and "as load heels while in I policy" and "Provide In an interview with Assistant) on 10/22 that the CNAs on tr responsible for perf resident's bath days Mondays and Thurs Flow Records for 19 that R53 received a showers on Monday 10/12, 10/15, 10/19 There was no docu occurred on R53's I through 10/18/09. C R53 complained that she discovered that E7 could not remen that she reported to the "buttock broke". Review of R53's "W dated 10/20/09 reve Stage 2 pressure u measured "L 2 W 0 flap of skin covering treatment was "Des 10/11/09) and the o intervention was "g. The facility updated and identified the "a	interventions included edistributing mattress", chair", "turn and reposition quess skin for redness", Officed Skin assessments per extreatments as ordered." E7 (day shift Certified Nursing /09 at 2:35 PM, she stated lee 3-11 PM shift were forming skin checks on the lee 3-11 PM shift were forming skin checks on the lee 3-13 bath days were on edays. Review of the CNA loog revealed documentation adaily partial bath and had the lys and Thursdays (10/9, 1/2009) on the 3-11 PM shifts. Intertation noting changes louttooks between 10/9/09 lon 10/22/09, according to E7, let his "bottom" was hurting and at the buttock (sacrum) "broke", in the buttock (sacrum) "broke", in the nurse that R53's skin on long that R53's skin on long that R53's skin on long that R53's let on his left buttock that let open area". The current sitin" (previously prescribed on lourrent preventative let cushion". If the care plan on 10/20/09 lectual Impaired skin integrity: if Sacrum (Stage2). The	F 31	4		

STATEMENT AND PLAN C	, OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) ML A. BUIL		LE CONSTRUCTION		(X3) DATE SI COMPLE	
		085026	B, WIN	G	a market	-	10/2	7/2009
NAME OF P	ROVIDER OR SUPPLIER			403	ET ADDRESS, CITY, STATE, ZIP 31 KENNETT PIKE REENVILLE, DE 19807	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREF)X TAG	,	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCY	ION SHOU HE APPRI	JLD BE	(X5) COMPLETION DATE
F 314	cushion(chair cushi interchangeable air and evenly distribut	ge 13 on that has individual cells that allow air to slowly e body weight pressure), Turn hrs. and assess skin for	F3	14	v			
	that previously, R53 recilner and or when he was uncomfortal stated that after sevattempted, he would	d ask the staff to take it off. He s room. She was not sure			•			
	ROHO cushion, the hours and assess s plan, they failed to hassure that interven	cility identified the use of a turning and positioning q 2-4 kin for redness in the care save a system in place to tions were consistently ored and or devices were opropriate						
	On 10/21/09 R53 warecliner without any	as observed seated in his seat cushion.						
	approximately 7:45 seated in his recline observed on the floodid not have the chastated that he used chair "about 4-5 day	with R53 on 10/22/09 at AM, R53 was observed r and the foam cushion was br. R53 acknowledged that he air cushion on the recliner. He to sit in a different type of a sago" and requested to have to his present recliner. He hair was small and			4			
		ulcer was re-evaluated by E3 on 10/22/09 and measured					•	

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STATEMENT AND PLAN C	ROF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/OLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SI COMPLE	
		085026	B. WING		10/2	7/2009
NAME OF P	ROVIDER OR SUPPLIER		40	EET ADDRESS, CITY, STATE, ZIP COI 131 KENNETT PIKE REENVILLE, DE 19807		
(X4) ID PREFIX TAG	EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(XS) COMPLETION DATE
F 314	"L 3.5 cm, W 1 cm Although the meas had increased, E3 The documented of interventions on the "Recliner 10/22,05 in recliner 10/22/05	age 14 , macerated left side". surement of the pressure ulcer documented it as "improving". current preventative e Wound Care sheet were all cushion in w/c, foam cut out out out out current care plan.	F 314			
F 315 SS=D		Y INCONTINENCE	F 315			
	assessment, the faresident who enter resident's clinical of catheterization was who is incontinent treatment and servinfections and to refunction as possible. This REQUIREMED by: Cross-refer to F31 Based on record refacility policy and path that the facility faller resident (R53) out residents, who was received appropriates or improve extent possible. Treatment in bladder admission) and failersure that appropriates and the same that appropriates are same	NT is not met as evidenced	2.	Resident 31 is now contine bladder. All residents are evaluated quarterly and with significal service education will be on the assessment of incontinuous changes in incontinence of schedules will be implement Nurses will be responsible day voiding diary to established to update the bowel and sessessment when a change	on admission ant change. In onducted relationated relations and to idented if approption complete alish a tolleting and bladder is noted. part of the C.I dimonthly by the any changes	ted to lentify lieting riate. 3-5 plan
	include.	THE RESIDENCE OF THE PARTY OF T		1	<u>Cii</u>	tel anopine
		- 65	F	III. ID. DESSSS		D 65 -601

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egates (FAX)3

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 12/04/2009 FORM APPROVED OMB NO. 0938-0391

	NOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE : COMPL	
	1997	085026	B. WING	1 144 144 144 144 144 144 144 144 144 1	10/	27/200 9
NAME OF P	RÖVIDER OR SUPPLIER SATES		403	ET ADDRESS, CITY, STATE, ZIP 11 KENNETT PIKE 1EENVILLE, DE 19807	***************************************	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	'ION SHOULD BE 'HE APPROPRIATE	(X6) COMPLETION DATE
F.315	Continued From p	age 15	F 315			
	The facility's policy and incontinence Management" was			0		
	diagnoses that inc (R) Rib, Fractured degeneration. Acc "Admission Asses resident was "cont bladder and had n	to the facility on 10/8/09 with luded S/P Fracture (FX) Right Right Clavicle and Left Macular ording to R53's Nursing sment" dated 10/8/09, this inent-complete control of bladder problems. R53 was				
	"Voiding Diary" (ev 10/8/09 through 10	liuretic medications. A 3 day very hour toileting) dated 0/10/09 was completed and was continent of bladder.				·
	documentation in the 10/11/09 through the discovered "grossing frequently inconting the discovered the through the	inical record revealed the nurse's note that starting 10/18/09 this resident was y incontinent urine" and/or ent of "large amount of urine". ssed about incontinent				
	stated, "able to ge well as placed urin	ed 10/19/09 and timed 7:05 AM this pants and attends down as al without difficultyneed Iling pants back up".				
	that he had worn p admitted here fron had more importal worry about "wettin 10/22/09, she state	n R53 on 10/22/09 he stated hads/depends since he was in the hospital. He stated that he not things to worry about than to ng". According to E7 (CNA) on ad that R53 "was depressed ing" due to his wife's recent				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

T-OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		
186	085026	B. WING		10/2	27/2009
PROVIDER OR SUPPLIER SATES		403	1 KENNETT PIKE		
(EACH DEFICIENT	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
According to R53' Data Set (MDS) a admission MDS a Indicated that this incontinent of blace according to these skills for daily dec Independence-sor only" and did not i memory problem. assistance with tra activities of daily li mobility related to claviole and use o The facility initiate deficit R/T Fx of ri Required" and dat included "Toileting	s Medicare 5-day Minimum ssessment dated 10/16/09, and ssessment dated 10/20/09 resident was "frequently dder (coded 3). Additionally, assessments, R53's cognitive ision-making were "modified me difficulty in new situations have a short and long term He needed extensive ensfer, toileting and all other lying due to his impaired his fractured right rib and f a sling to his right arm. d a care plan on "Self-care be and clavicle: Assistance led 10/20/09 The interventions s Assist: One person extensive	F 315			
facility lacked doci the resident's inco that the facility init 10/16/09 and 10/2 interventions such prompted voiding, interventions to try incontinence. During an interview 10/22/09 at approvacknowledged that schedule in place "voiding diary" (toll	umentation that the causes of ntinence were assessed nor lated a care plan prior to 0/09 to address appropriate as a scheduled toileting, a toileting trial, or other to manage and monitor R53's with E8 (MDS Coordinator) on kimately 3:45 PM, she t there was no toileting and that R53 needed another leting trial) and an individualized				
	SUMMARY S' (EACH DEFICIENT REGULATORY OR REGULATORY OR According to R53' Data Set (MDS) a admission MDS a indicated that this incontinent of blac according to these skills for daily decondependence-solonly" and did not imemory problem. assistance with tractivities of daily limemory problem. The facility initiate deficit R/T Fx of rince assist Handrail in Provide urinal". Review of R53's continuity lacked document the facility initiated the facility initiated the resident's incontinent to try incontinence. During an interview 10/22/09 at approximations to try incontinence. During an interview 10/22/09 at approximations daily in place "voiding diary" (tol.)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 According to R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/16/09, and admission MDS assessment dated 10/20/09 indicated that this resident was "frequently incontinent of bladder (coded 3). Additionally, according to these assessments, R53's cognitive skills for daily decision-making were "modified independence-some difficulty in new situations only" and did not have a short and long term memory problem. He needed extensive assistance with transfer, tolleting and all other activities of daily living due to his impaired mobility related to his fractured right rib and clavicle and use of a sling to his right arm. The facility initiated a care plan on "Self-care deficit R/T Fx of ribs and clavicle: Assistance Required" and dated 10/20/09 The interventions included "Tolleting Assist: One person extensive assistHandrail in BR (bathroom) for toileting and Provide urinal". Review of R53's clinical record revealed that the facility lacked documentation that the causes of the resident's incontinence were assessed nor that the facility initiated a care plan prior to 10/16/09 and 10/20/09 to address appropriate interventions such as a scheduled toileting, prompted voiding, a toileting trial, or other interventions to try to manage and monitor R53's	SATES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 16 According to R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/16/09, and admission MDS assessment dated 10/20/09 Indicated that this resident was "frequently incontinent of bladder (coded 3). 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Additionally, according to these assessments, R53's cognitive skills for daily decision-making were "modified Independence-some difficulty in new situations only" and did not have a short and long term memory problem. He needed extensive assistance with transfer, tolleting and all other activities of daily living due to his impaired mobility related to his fractured right rib and clavicle and use of a sling to his right arm. The facility initiated a care plan on "Self-care deficit R/T Fx or ribs and clavicle: Assistance Required" and dated 10/20/09 The interventions included "Tolleting Assist. One person extensive assistHandrial in BR (bathroom) for tolleting and Provide urinal". 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During an Interview with E8 (MDS Coordinator) on 10/22/09 at approximately 3:45 PM, she acknowledged that there was no toileting she acknowledged and that the acknowledged and hard without and and individualized	DENTIFICATION NUMBER: 085028 STREET ADDRESS, CITY, STATE, ZP ODDE 4031 KENNETT PIKE SUMMARY STATEMENT OF DETICIENCIES (RACH DEROISINO'N MUST BE PROCEED BY TULL (RECULATION' OR LSC IDENTIFYING INFORMATION) COntinued From page 18 A Coording to R53's Medicare 5-day Minimum Data Set (MDS) assessment dated 10/16/09, and admission MDS assessment dated 10/16/09, and admission MDS assessment dated 10/16/09, and admission MDS assessment dated 10/16/09, and independence-some difficulty in new situations only' and did not have a short and long term memory problem. He needed extensive assistance with transfer, folieting and all other activities of daily living due to his impaired mobility related to his fractured right rith and clavicle and use of a sling to his right arm. 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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SE COMPLE	
		085026	B. WING		10/2	7/2009
NAME OF P	ROVIDER OR SUPPLIER		STRI	ET ADDRESS, CITY, STATE, ZIP CODE		772000
STONEG	ATES		40	31 KENNETT PIKE REENVILLE, DE 19807		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	id Prefix Tag	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(XI) COMPLETION DATE
F 315	Continued From pa	ige 17	F 315			
F 444 SS=D	diary on 10/22/09 the which indicated the episodes since he 483.65(b)(3) PREV	acility completed a volding nrough 10/24/09, the results of at R53 did not have incontinent was toileted every hour.	F 444	· .		
			 F- 1.	444 The wound care and hand was reviewed with the nurs 10/22/09.	•	Y
	by: Based on observation procedure and interest the facility failed to handwashing was of dressing change for 18 sampled stage 2. The facility's Policy Hygiene" was revied the facility's Policy Hygiene as revied to 10:30 AM. The for the wound dressing set up on top of the	erved during a wound r 1 (one) resident (R53) out of 2 residents. Findings include: entitled "Handwashing/Handwed. erved performing wound care alight ankle wound on 10/22/09 ollowing were observed during a treatment:: A clean field was a resident's bedside table.	3.	All nursing staff will be educe proper procedure for hand wound care procedure. A wound care competency conducted for all licensed standard return demonstration wound care procedure. A random audit will be conducted on a basis and reported on through improvement committee.	washing and will be raff which will on of the lucted on the quarterly gh the qualit responsible	·
	on top of a clean to wash her hands pri gloves. She then pri dressings on R53's	fortably in bed with his right leg wel. E4 was not observed to or to donning a pair of clean roceeded to remove the soiled right ankle wound. A trash ic bag was located against the		# *** *** *** *** *** *** *** *** *** *		12/31/09 and angoing

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	COF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUIL	DING	TION	(X3) DATE S COMPLI	
		085026	B. WING	3 <u> </u>	200	10/2	7/2009
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, 4031 KENNETT F GREENVILLE,	- 18 N		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFD TAG	(EACH C	IDER'S PLAN OF CORR CORRECTIVE ACTION S FERENCED TO THE AF DEFICIENCY)	HOULD BE	(XS) COMPLETION DATE
F 444	wall inside the root reach. E4 procees contaminated glow dressing, donned without handwash handrub. E4 clear normal saline solutine hydrogel ointre E4 removed only likept her soiled left removing both. Shright hand without left hand with the glove on the right around the wound gauze, then applies wound. E4 removing the bathroom a without handwash entire wound treat supplies used to the were piled on one placed under R53 right leg instead or away from the resund collected all supplies piled up of leg with her glove trash can located E4 did not wash his based hand rub at contaminated glow to put his shoes but her shoes but her glove trash can located can be and removing glow clean dressing change and removing glow clean dressings, at the contaminated glow clean dressings.	m but was not within E4's ded to remove her res after handling the soiled a new pair of clean gloves ing or using an alcohol based sed the ankle wound with a sed the proceeded to apply the new to the proceeded to apply the soiled right hand glove and the hand glove instead of the donned a clean glove on her first handwashing and used the contaminated glove to place the contaminated glove to place the hand. E4 cleansed the area with a prepared skin prepared skin prepared skin prepared to the Tegaderm cover to the wed both gloves and then went and donned a new pair of gloves ling. Additionally, during the ment procedure, all soiled reat and cleanse the wound side of the towel that was a right leg and adjacent to his f placing them in a plastic bag lident. E4 finished the treatment oiled dressing/treatment on the towel next to R53's right d hands and threw them in the against the wall of the room, ands and/or use an alcohol iter she removed her res. E4 proceeded to help R53 ack on. The soiled dressings wound after handling soiled dressings were and before handling the and after removing and	F 4				
ORM CMS-26	587(02-89) Previous Version	ns Obsolete Event ID: PRI£11		Facility ID: DE00220	If co	ntinuation sheet	Page 19 of 21

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STATEMENT AND PLAN Ó	COF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			B. WING		
		085026	0.77774		10/27/2009
NAME OF P	ROVIDER OR SUPPLIER		40	EET ADDRESS, CITY, STATE, ZIP CODE 31 KENNETT PIKE REENVILLE, DE 19807	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 444	disposing of solled accordance with int current standards of	dressing supplies in fection control practices and for practice.	F 444	,	
F 514 SS=D	E2 (Director of Nurs 483.75(I)(1) CLINIC	T'	F 514	i i i i i i i i i i i i i i i i i i i	
	resident in accorda standards and prac	nce with accepted professional tices that are complete; nted; readily accessible; and	F-514 1.	The resident's weight is sta	
	information to ident resident's assessm services provided;	ening conducted by the State;	2.	her preference. Nursing staff will be in-servi acceptable professional star documentation. Medical administration reco	ndard of
	This REQUIREMED by: Based on record redetermined that the the clinical record for 18 sampled Stage 2 accordance with accordance with accordance.	NT is not met as evidenced view and interview, it was facility failed to ensure that or one (1) resident (R10) out of 2 residents was maintained in accurately	4.	administration records will by the shift supervisor to de appropriate documentation	be reviewed weekly stermine will be reviewed
	Glucerna 1 can twice medication adminis	n's order, dated 8/3/09 for ce a day. Review of the 8/09 tration record (MAR) revealed no signatures to indicate that ot given.			12/31/09 and ongeing
	During an interview	with E5 (nurse) on 10/23/09			

STATEMEN) AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE 8 COMPL	
		085026	B. WING		10/2	27/2009
NAME OF P	ROVIDER OR SUPPLIER		403	ET ADDRESS, CITY, STAT E Z IP 11 KENNETT PIKE EENVILLE, DE 1980 7		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCE) TO T DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(XS) COMPLETION DATE
F 514	had many blanks for though the resident	ge 20 nowledged that the 8/09 MAR or the Glucerna and that even was refusing it many times it ocumented on the MAR.	F 514			

	OF ISOLATED DEFICIENCIES WHICH CAUSE ITH ONLY A POTENTIAL FOR MINIMAL HARM ID NFs	PROVIDER # 085026		ONSTRUCTION	DATE SURVEY COMPLETE: 10/27/2009
NAME OF PRO	OVIDER OR SUPPLIER	STREET ADDRESS, CIT 4031 KENNETT PII GREENVILLE, DE	KE		
D PREFIX FAG	SUMMARY STATEMENT OF DEFICIE	:NCIES			
F 466	483.70(h)(1) PROCEDURES TO ENS The facility must establish procedures of normal water supply.			al areas when there i	s a loss
	This REQUIREMENT is not met as e Based on review of the emergency pro- address the source of non-potable water	cedures on 10/23/09, th	ne emergency wate	r procedure was fou	nd not to
	Review of the emergency water proced water was covered as part of an emerge procedure. Review of this procedure w facility did not have a procedure that catanker if necessary.	ency water loss. The novith E14 (maintenance st	n-potable water wataff) on 10/23/09 a	s not covered in the t 9:20 AM revealed	that the
	Review of the procedures with E1 (Adfrom the city and they would use whate facility. On 10/26/09 at 11:15am, a copsource: City of Wilmington Disaster Pl stated to save one gallon of water per pqts for drinking and 2 quarts for each p	ever they had in place a py of a document entitle lan) was given to the su person per day and keep person in your househol	Ithough they did no ed "Prepare a Fami rveyor which conta at least a 3 day su	ot have this procedur ly Emergency Kit" (ained a paragraph on pply of water per pe	e at the online water. It
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

研究。

The above isolated deficiencies pose no actual harm to the residents



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OF DEFICIENCIES ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH	ANTICIPATED DATES TO BECORRECTED	34
STATEMENT OF DEFICIENCIES	Specific Deficiencies	
SECTION		

3201	The State Report incorporates by reference and also cites the findings specified in the Federal Report. An unannounced QIS annual survey was conducted at this facility from October 19, 2009 through October 27, 2009. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other documentation as indicated. The facility census the first day of the survey was 41. The survey sample included forty (40) census sample residents and twelve (12) admission sample residents in Stage 1. The Stage 2 sample totaled eighteen (18) residents.		
3201.6.0	Services To Residents		
3201.6.1	General Services		
3201.6.1.1	The nursing facility shall provide to all residents the care necessary for their comfort, safety and general well-being, and shall meet their medical, nursing, nutritional, and psychosocial needs.		·

Provider's Signature Kinn M. Cann

Title Oxlmmnstraton



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
		F-157
	This requirement is not met as evidenced by:	1. The physician was notified of the resident's continence status
	Cross-refer to CMS 2567-L, survey date completed	at the time of the survey. 2. Notification of the appropriate party will be documented in the
3201.6.5	Nursing Administration	changes in condition or treatment.
3201.6.5.7	The assessment and care plan for each	3. Licensed staff will be in- serviced on the regulatory requirement
	resident shall be reviewed/revised as needed when a significant change in physical or mental	4. All documented notification will be indicated on the 24-hour
	condition occurs, and at least quarterly. A	report which is reviewed daily by the DON/ADON.
	complete comprehensive assessment shall be conducted and a comprehensive care plan shall be developed at least yearly from the date	Completion date 12/30/09
	of the last full assessment.	
-	This requirement is not met as evidenced by:	
	Cross-refer to CMS 2567-L, survey date completed 10/27/09, F279 and F280.	
3201.6.10	Records and Reports	
3201.6.10.1	There shall be a separate clinical record maintained on each resident as a chronological	
	history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the	



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F-315

This requirement is not met as a

- Resident 53 is now continent of bowel and bladder.
- changes in incontinence of residents. Tolleting schedules will be All residents are evaluated on admission quarterly and with significant change. In-service education will be conducted related to the assessment of incontinence and to Identify Implemented if appropriate. 'n
 - Nurses will be responsible to complete a 3-5 day voiding diary to establish a tolleting plan and to update the bowel and bladder assessment when a change is noted.
- The tolleting plan will be a part of the C.N.A. flow sheet and be reviewed monthly by the DON/designee to determine any changes in continence status.

Completion: 12/31/09 and ongoing

Cross-refe)

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201201.6.10.1



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
3201.6.5	This requirement is not met as evidenced by: Cross-refer to CMS 2567-L, survey date completed 10/27/09, F157, F314, F315, and F444. Nursing Administration The assessment and care plan for each	 F-444 The wound care and hand washing policy was reviewed with the nurse on 10/22/09. All nursing staff will be educated on the proper procedure for hand washing and wound care procedure. A wound care competency will be conducted for all licensed to the standard of the standard of
	resident shall be reviewed/revised as needed when a significant change in physical or mental condition occurs, and at least quarterly. A complete comprehensive assessment shall be conducted and a comprehensive care plantshall be developed at least yearly from the date of the last full assessment. This requirement is not met as evidenced by:	care procedure. 4. A random audit will be conducted on the wound care procedure on a quarterly basis and reported on through the quality improvement committee. 5. The ADON/designee will be responsible for the oversight and monitoring of wound care. Completion: 12/31/09 and ongoing
3201.6.10	Records and Reports	
3201.6.10.1	There shall be a separate clinical record maintained on each resident as a chronological history of the resident's stay in the nursing facility. Each resident's record shall contain current and accurate information including the	



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ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH	CLF C CLF	ANTICIPATED DATES TO BE CORRECTED	
STORENT OTTAKENT OF BEIDENDIES	7	Specific Deficiencies	

SECTION	STATEMENT OF DEFICIENCIES	ADM	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	following:	F-314	
3204.6.10.1.7	Medication administration record (MAR)		The resident's wound was healed stage II as of 10/23/09
	including medications, dosages, frequency,	7.	All residents have appropriate treatment and services to
	route of administration, and initials of the nurse		prevent pressure ulcers. Weekly skin assessments are
	administering each dose. The record shall		conducted with nurse/C.N.A. Findings are documented and
-	include the signature of each nurse whose		interventions implemented as appropriate.
	initials appear on the MAR.	ന്	Pressure ulcer care plans will be updated to reflect actual
	This requirement is not mot as avidanced hv.		alteration in skin integrity for all residents with pressure
	Instequiements not met as evidenced by:		wounds. The documentation will include the location and stage
	Cross refer to CMS 2567-L, survey date completed		of the wound on the care plan.
		4	The ADON/designee will review the care plan and wound care
			documentation weekly to ensure the care plan has been
16 <u>Del. C.,</u>	Patient's rights		reviewed and revised for appropriate interventions and
Chapter 11,			documentation of alteration in skin integrity is noted on the
Subchapter II,			care plan.
§ 1121	purpose of this section, to promote the merest	පි	Completion: 11/30/09 and ongoing
	sanitoria, rest homes, nursing homes, boarding		
	homes and related institutions. It is declared to	- ·· · · · · ·	
	be the public policy of this State that the		
	interest of the patient shall be protected by a		
	declaration of a patient's rights, and by	· · · · · · · · · · · · · · · · · · ·	
	requiring that all facilities treat their patients in		
	include but not be limited to the following:		
	-	<u>-</u>	-
	(1) Every patient and resident shall have the		



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	TES TO BE CORRECTED.	
MAINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES	NTICIPATED DATES TO BE CORREGIED.	
TAGINISTINITATION	ADMINIOTICS AND ADMINISTRATION OF THE PESTA	
	STATEMENT OF DEFICIENCIES Specific Deficiencies	
NAME OF FACILII Y: STOTIENARES	SECTION STATEMENT OF DEFICIENCE Specific Deficiences	

following: 3201.6.10.1.7

route of administration, and initials of the nurse including medications, dosages, frequency, include the signature of each nurse whose administering each dose. The record shall Medication administration record (MAR) initials appear on the MAR.

This requirement is not met as evidenced by:

Cross refer to CMS 2567-L, survey date completed 10/27/09, F514

Patient's rights

Chapter 11 16 Del. C.,

homes and related institutions. It is declared to sanitoria, rest homes, nursing homes, boarding requiring that all facilities treat their patients in It is the Intent of the General Assembly, and the purpose of this section, to promote the interest and well-being of the patients and residents in interest of the patient shall be protected by include but not be limited to the following accordance with such rights, which shall be the public policy of this State that the declaration of a patient's rights, and by Subchapter II, § 1121

(1) Every patient and resident shall have the

The resident's weight is stable. The resident receives glucerna or ensure pudding based on her preference.

Nursing staff will be in-serviced on the acceptable professional standard of documentation.

Medical administration records and treatment administration records will be reviewed weekly by the shift supervisor to determine appropriate documentation.

Any missing documentation will be reviewed with the appropriate nurse. 4

The ADON/DON will monitor compliance with documentation standards.

Completion: 12/31/09 and ongoing



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ANTICIPATED DATES TO BE CORRECTED
		F-279
	right to receive considerate, respectful, and	
	appropriate care, treatment and services, in	 Care plans for all four residents have been updated
	compliance with relevant federal and state law	2. Nursing will be educated on the care plan process to review and
	and regulations, recognizing each person's	revise care plans as indicated.
	basic personal and property rights which	3. Nurses will review resident care plans when competing monthly
	include dignify and individuality.	
	This requirement is not met as evidenced by:	required.
		4. The 24-hour report which is completed by the nursing
	Cross-refer to CMS 2567-L survey date completed	supervisor on each shift and is reviewed daily by the
	10/27/09, F241.	DON/ADON will indicate if the care plan was evaluated or
		revised.
		5. The DON/ADON will review the care plan for accuracy.
	-	Completion: 12/30/09 and ongoing



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ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH	ANTICIPATED DATES TO BE CORRECTED	
SECTION STATEMENT OF DEFICIENCIES ADMINISTRA		F-280

ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED		087-1	1. Resident 53 has an appropriate cushion which he finds to be	law satisfactory. Resident 51's care plan was updated on 8/25/09	with the appropriate PT recommendation from 8/21/09.	2. All care plans will be reviewed and revised based on new	interventions and will be documented as such when indicated.	y: Nursing staff will be in-serviced on the care plan process.	3. All incidents, new orders, and changes in clinical conditions will	eted be documented on the 24-hour report and added to the care	plan as appropriate.	4. The shift supervisor will review the 24-hour report and cross	reference nurses notes and care plans to ensure the care plans	have been reviewed and revised.	5. The ADON/DON will monitor the care planning process to	assure information is timely.	Completion: 11/30/09 and ongoing	
STATEMENT OF DEFICIENCIES	Specific Deficiencies	I right to receive considerate, respectful, and	appropriate care, treatment and services, in	compliance with relevant federal and state law	and regulations, recognizing each person s	basic personal and property rights which		This requirement is not met as evidenced by:		Cross-refer to CMS 2567-L survey date completed	10/27/09, F241.							
SECTION						-		-						-				



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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH
	right to receive considerate, respectful, and	F-241
	appropriate care, treatment and services, in	All health care staff will be in-serviced regarding the positive dining
	and requiretions recognizing each berson's	experience. General rules regarding interaction between resident
	hasic personal and property rights which	and staff will be posted in both pantry areas in addition to the in-
	Include dignity and individuality.	service. Nursing supervisor will monitor the dining experience of our
-		residents to ensure the dining experience is one that promotes
	This requirement is not met as evidenced by:	dignity and quality of life of our residents. A nurse will be
-	potological Long Caro	designated to oversee the dining room during the meal service. This
	Cross-refer to CMS 2007-L survey data continued at 10/27/09, F241.	monitoring will be on going for all meals.

Completion: 12/31/09 and ongoing